

Advance Telemedicine, LLC

Patient Consent, Policies and Acknowledgements

For Patients in Connecticut and Maine

This form applies to patients who are residents of, and who are physically located in, the State of Connecticut or the State of Maine at the time of their telehealth encounter with Advance Telemedicine, LLC (the “Practice”). Provisions that apply to only one of the two states are identified by that state’s name. Please read this entire form carefully and ask any questions before signing. A copy of this form is available for you to print or request at any time.

1. Payment Policy

Payment for services is collected at the time of the visit — not before. No advance payment is required to schedule, confirm, or hold your appointment.

- Payment is due at the time of service, on the date of your visit.
- Accepted payment methods: credit/debit card and HSA/FSA card.
- If you are using insurance, you are responsible for any copayment, coinsurance, deductible, or amount not covered by your plan. Those amounts are due at the time of service.

Connecticut patients — required payment terms (Conn. Gen. Stat. § 19a-906(i)). Before providing services to you, the Practice will determine whether you have health coverage for the service and, if you do, whether you elect to use that coverage or to pay the Practice directly. The following terms apply:

- If you use your health coverage, the Practice will accept as full payment the amount your coverage reimburses, plus any coinsurance, copayment, deductible, or other out-of-pocket amount imposed by your plan — unless you have explicitly elected to pay the Practice directly without using your coverage.
- If you do not have health coverage for the service, the Practice will accept as full payment an amount equal to the amount that Medicare reimburses for that service.
- If you elect to pay the Practice directly, in whole or in part, the Practice will disclose the cost of the service to you before the service is provided, and you and the Practice may mutually agree on the amount.
- If the Practice determines that you are unable to pay, the Practice will offer you financial assistance to the extent required by applicable state or federal law.
- Nothing in this paragraph prevents you from paying the Practice directly for services without seeking coverage from your health carrier.

Maine patients: payment terms are as described in the general provisions above. Questions about payment or your account may be directed to 1-800-835-9812 or info@advancetelemedicine.com.

2. Late Policy

After 15 minutes from the scheduled appointment time, the appointment will be canceled if no one is present, and the appointment will need to be rescheduled. A no-show fee will be charged.

3. No-Show Fee

A \$50.00 no-show fee will be charged if the appointment is not canceled in advance.

4. To Cancel or Reschedule

Call 1-800-835-9812 or email info@advancetelemedicine.com.

5. Insurance Authorization and Assignment

Advance Telemedicine, LLC providers and staff are dedicated to providing the best possible care and services, which may include diagnostic tests. We have adopted the following policies in order to minimize confusion or misunderstanding between our patients and the Practice. Please provide a copy of your insurance card to attach to your file, or allow us to photocopy your insurance card.

Some diagnostic tests that will be done at your visit may be covered by your medical insurance carrier. If they are not covered by your medical insurance, you will not receive a bill from the laboratory doing the testing or from Advance Telemedicine, LLC. You may receive an EOB statement, but that is not a bill and no remittance is required on your part.

I hereby authorize Advance Telemedicine, LLC to furnish all necessary information to my insurance carrier concerning any of my or my dependent's illness and treatment. I hereby authorize Advance Telemedicine, LLC to release my insurance information to a third-party billing service for services related to my treatment process. I hereby assign to the third-party billing service or supplier all payments for medical services rendered to me or my dependents. I have read and fully understand the policies of this Practice regarding payments and insurance.

6. Notice of Privacy Practices — Patient Acknowledgement and Authorization for Use/Disclosure of Protected Health Information (PHI)

I have received the Practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my PHI that may be made by this Practice. I understand that this Practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all PHI at, or controlled by, this Practice. I understand I can obtain this Practice's Notice of Privacy Practices on request.

I authorize the use and disclosure of all health information for the purpose of treatment, payment, and health care operations. I authorize Advance Telemedicine, LLC and its staff to use and disclose my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and may no longer be protected. I understand that any revocation does not apply to disclosures or uses of PHI that have occurred prior to my revocation.

7. Patient Manner of Contact

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that a verbal request is an acceptable authorization for the use of any alternate contact method, number, and/or location, as well as for a change in the manner listed below. I understand that this Practice calls to confirm appointments at the number I give. I understand that by signing this form I

am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

Alternate contact method, number, and/or location authorized by me (if any):

8. Authorization for Release of Confidential Records

I hereby authorize Advance Telemedicine, LLC to disclose and verify me as a patient to any law enforcement agency, my physician(s), Child Protective Services, or any Connecticut or Maine state-licensed dispensary facility. This is valid during the period of time for which the recommendation has been issued. This consent is subject to written revocation only, at any time, except to the extent that action has already been taken on the basis of this consent.

I give Advance Telemedicine, LLC and the healthcare providers permission to validate my status as a patient using the online patient verification system. I give permission for my medical records, file, and insurance information to be reviewed by another physician or laboratory working with Advance Telemedicine, LLC. I understand that this might happen if the original doctor that evaluated me required a secondary opinion, is not available, is off premises, or has moved or terminated his/her practice.

9. Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition, and I attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing, or distributing medical marijuana. I attest that I am not a member, employee, or agent of any media or law enforcement agency.

It is illegal to film or record in this office (virtual or in-person) with a video camera, cell phone, or any other recording device, whether a still image, video, or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality. I am aware that my recommendation can be revoked at any time, and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions, or have falsified any medical records provided to the physician.

I also hereby authorize Advance Telemedicine, LLC or its representative to discuss my medical condition. Additionally, I acknowledge the healthcare provider informed me of the nature of a recommended treatment, including but not limited to any recommendation regarding medical marijuana; the risks, complications, and expected benefits of any recommended treatment, including its likelihood of success or failure. I acknowledge the healthcare provider informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The provider may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all of the above regardless of whether or not I qualify as a patient.

10. Release of Liability

I attest that the information on this form is correct, and any medical history presented or discussed with the provider is factual and complete to the best of my knowledge. I do not plan or intend to use my provider's recommendation for the purpose of illegally obtaining medical marijuana. I authorize Advance

Telemedicine, LLC to converse, electronically submit, and release information regarding my medical condition.

I understand that I must be a resident of the state in which my certification is issued in order to obtain an approval or recommendation for the use of medical cannabis. Connecticut requires a qualifying patient to be a Connecticut resident who is treated for a debilitating medical condition by a Connecticut-licensed physician, physician assistant, or advanced practice registered nurse. Maine requires a qualifying patient to be a Maine resident who has been a resident of the State for at least 30 days and who holds a valid written certification issued by a Maine-licensed medical provider (physician, certified nurse practitioner, or physician associate).

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found, or am interested in finding out, whether or not medical marijuana provides substantial relief and improvement in my condition. I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities, and/or contaminants. I understand the potential risks associated with elevated daily consumption of medical marijuana, including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood, and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately. I was also advised that the use of medical marijuana might affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

Connecticut's palliative use of marijuana statutes (Conn. Gen. Stat. § 21a-408 et seq.) and Maine's Medical Use of Cannabis Act (22 M.R.S. § 2421 et seq.) provide for the possession of medical cannabis by a patient who has a provider's approval, recommendation, or written certification. It should be made clear that the physician, staff, and representatives of this Practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the provider for purposes of determining the appropriateness of medical marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me, and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care provider. Should an approval be made for my medical use of marijuana, I understand that there is a renewal date specified by the provider depending on the condition. I understand that it is my responsibility to see the provider to assess the possible continuance of cannabis use beyond the term of the approval. Furthermore, the undersigned, or anyone acting on my behalf, holds Advance Telemedicine, LLC, the physician, and his/her principals, agents, and employees free of and harmless from any liability resulting from my release, a data

breach, and my use of medical marijuana. I further understand that by signing below, I am authorizing the release of any part of this record.

11. Acknowledgements, Agreements, Disclosures and Informed Consent

I understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. I have been advised that the use of medical marijuana may affect my coordination, motor skills, and cognition in ways that could impair my ability to drive, and I agree not to operate heavy machinery, drive, or engage in potentially hazardous activities while using it.

I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana may include but are not limited to: euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short-term memory, inability to concentrate, suppression of the body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, lack of physical coordination, paranoia, and increased appetite.

I understand that some patients may become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal may include feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances, and unusual tiredness. I understand the chronic use of medical marijuana may lead to laryngitis, bronchitis, and general apathy. I understand that although marijuana does not produce a specific psychosis, it may exacerbate schizophrenia and persons predisposed to that disorder. I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide, or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above.

Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and/or medication that stabilizes my mental or physical condition. I understand there are few known interactions between marijuana and medications other than herbs; however, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements, or other medications.

Federal regulatory status of marijuana. I am aware that the United States Food and Drug Administration (FDA) has not approved a marketing application for cannabis for the treatment of any disease or condition, and that the FDA has not determined marijuana to be safe and effective as a drug. I understand the significance of this fact.

Federal classification of marijuana. I am aware that marijuana is a controlled substance under federal law, that its status under federal law differs from its status under Connecticut and Maine law, and that federal law may change. I understand that, effective April 28, 2026, marijuana contained in an FDA-approved drug product and marijuana subject to a qualifying state medical marijuana license were placed in Schedule III of the federal Controlled Substances Act (91 Fed. Reg. 22714). I further understand that other forms of marijuana — including unlicensed bulk marijuana, marijuana extract, and synthetic tetrahydrocannabinols — remain in Schedule I, and that a separate federal proceeding is pending that could change marijuana's federal schedule again. Nothing in this form is a representation or guarantee by the Practice as to the current or future federal classification of marijuana.

I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission from the drug for at least 3 weeks every 3 to 4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician. I understand the benefits and risks associated with the use of marijuana are not fully understood, and that the use of marijuana may involve risks that have not been identified. I accept such risk. I understand that should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report any such problems or effects to the provider.

Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers in the lungs, mouth, and tongue. I have been advised that alternative delivery methods, such as vaporizers and oils, may substantially reduce the harmful effects of smoking.

I understand marijuana varies in potency. The effects of marijuana may also vary with the delivery method. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, heart rhythm disturbances, numbness in the limbs, anxiety attacks, and incapacitation. If I start taking medical marijuana, I agree to tell my provider if I: start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or experience any other side effect that is not to my liking.

I agree that if I am a female patient, I will contact my provider if I become pregnant or am thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breast-feeding. I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana. I understand that I should not be driving a vehicle while using marijuana, and that I can get a DUI for driving under the influence.

Medical marijuana is not regulated by the US FDA and therefore may contain unknown quantities of active ingredients, impurities, and/or contaminants.

I agree to follow up with the attending physician at Advance Telemedicine, LLC with supporting medical records pertaining to my medical conditions. I understand that the attending physician, staff, and/or representatives of Advance Telemedicine, LLC are neither providing, dispensing, nor encouraging me to obtain medical marijuana. I certify that I have read this document and declare under penalty of perjury that the information contained herein is true, correct, and complete. I acknowledge that any manipulation, alteration, or falsification of this form will result in the immediate termination of the letter of recommendation and of any legal right to my use of medical marijuana. Furthermore, the above-mentioned activities will be reported to the appropriate local authorities. The physician, staff, and representatives of Advance Telemedicine, LLC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on my behalf, hold Advance Telemedicine, LLC, the physician, his/her principals, agents, and employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

12. Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining the expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision-making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reaction, or other judgment error.

By signing this form, I attest to and understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Advance Telemedicine, LLC has explained the alternatives to my satisfaction.
- I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform Advance Telemedicine, LLC of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- **I attest that I am physically located in the State of Connecticut or the State of Maine at the time of each telehealth encounter, and that I will be physically present in one of those two states for the duration of every telehealth encounter with Advance Telemedicine, LLC.**

State-Specific Notices

Connecticut

- At the time of your first telehealth interaction, your provider will inform you of the treatment methods and limitations of treatment using a telehealth platform and will obtain your consent to receive telehealth services. That notice and consent will be documented in your health record. If you later revoke your consent, the revocation will also be documented in your health record (Conn. Gen. Stat. § 19a-906(b)(2)).
- Your provider will ask whether you consent to disclosure of records concerning the telehealth interaction to your primary care provider. If you consent, those records will be provided to your primary care provider in a timely manner (Conn. Gen. Stat. § 19a-906(d)).
- Connecticut law limits the prescribing of Schedule I, II, and III controlled substances through telehealth to medication-assisted treatment and the treatment of persons with psychiatric disabilities or substance use disorders (Conn. Gen. Stat. § 19a-906(c)).
- Payment terms required for Connecticut telehealth patients, including the Practice's acceptance of an amount equal to the Medicare reimbursement amount as payment in full when a patient does not have health coverage, are set out in Section 1 of this form (Conn. Gen. Stat. § 19a-906(i)).

Maine

- Telehealth services are provided by a licensee acting within the scope of the licensee's license, in accordance with applicable standards of practice, and in compliance with all state and federal confidentiality and privacy laws (32 M.R.S. § 13868).
- To receive a Maine medical cannabis written certification, you must be a Maine resident who has been a resident of the State for at least 30 days, and your written certification must be issued by a Maine-licensed medical provider — a physician, certified nurse practitioner, or physician associate (22 M.R.S. § 2421-A).
- If you are not a Maine resident, or have been a Maine resident for fewer than 30 days, you may be eligible for care as a visiting qualifying patient under Maine law; please discuss your eligibility with your provider before your visit.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize Advance Telemedicine, LLC to use telemedicine in the course of my diagnosis and treatment.

Patient Acknowledgement and Signature

By signing below, I confirm that I have read and understand this entire form, including the payment policy, late policy, no-show fee, insurance authorization and assignment, Notice of Privacy Practices acknowledgement, manner of contact authorization, authorization for release of confidential records, medical marijuana patient declaration, release of liability, acknowledgements and informed consent, and the informed consent for telemedicine services.

Patient name (print)	_____
Date of birth	_____
State of residence (CT or ME)	_____
Patient signature	_____
Date	_____
Legally authorized representative (if applicable)	_____
Relationship to patient	_____
Representative signature	_____
Date	_____

Provider / Practice use only

Provider name and credentials	_____
Provider signature	_____
Date	_____
Consent obtained and documented in the patient's health record	_____